This form must be completed electronically. Handwritten forms will not be accepted.

POST-DEPLOYMENT HEALTH RE-ASSESSMENT (PDHRA)

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, 1074f, 5013, 5013, 8013 and E.O. 9397.

PRINCIPAL PURPOSE(S): To assess your state of health after deployment in support of military operations and to assist military healthcare providers in identifying and providing present and future medical care you may need. The information you provide may result in a referral for additional healthcare that may include medical, dental or behavioral healthcare or diverse community support services.

ROUTINE USE(S): In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, to other Federal and State agencies and civilian healthcare providers, as necessary, in order to provide necessary medical care and treatment.

DISCLOSURE: Voluntary. If not provided, healthcare WILL BE furnished, but comprehensive care may not be possible.

INSTRUCTIONS: Please read each question completely and carefully before entering your response or marking your selection. YOU ARE ENCOURAGED TO ANSWER EACH QUESTION. Withholding or providing inaccurate information may impair a healthcare provider's ability to identify health problems and refer you to appropriate sources for additional evaluation or treatment. If you do not understand a question, please ask for help. Please respond based on your MOST RECENT DEPLOYMENT.

DEMOGRAPHICS

Last Name: ARROYO

First Name: LUZMARIA

Middle Initial:

Social Security Number: 321-70-9075

Date of Birth: 01-Jan-1981

Today's Date (dd/mmm/yyyy): 05-Oct-2010

Date arrived theater (dd/mmm/yyyy): 17-May-2009

Date departed theater (dd/mmm/yyyy): 06-Apr-2010

Gender: ○ Male ◉ Female

Service Branch: ○ Air Force ◉ Army ○ Navy ○ Marine Corps ○ Coast Guard ○ Civilian Employee ○ Other

Marital Status: ○ Never Married ◉ Married ○ Separated ○ Divorced ○ Widowed

Status Prior to Deployment: ○ Active Duty ◉ Selected Reserve - Reserve - Unit ○ Selected Reserves - Reserve - AGR ○ Selected Reserves - Reserve - IMA ○ Selected Reserves - National Guard - Unit ○ Selected Reserves - National Guard - AGR ○ Ready Reserves - IRR ○ Ready Reserves - ING ○ Civilian Government Employee ○ Other

Pay Grade: ○ E1 ○ E2 ○ E3 ○ E4 ○ E5 ◉ E6 ○ E7 ○ E8 ○ E9 ○ O1 ○ O2 ○ O3 ○ O4 ○ O5 ○ O6 ○ O7 ○ O8 ○ O9 ○ O10 ○ W1 ○ W2 ○ W3 ○ W4 ○ W5 ○ Other

Locations of Operation (In what theater were you mainly deployed (land-based operations more than 30 days)? Please mark all that apply, including the number of months spent in each location.)

Country 1: IRAQ	Months: 12
Country 2:	Months:
Country 3:	Months:
Country 4:	Months:
Country 5:	Months:

Since return from deployment I have: ◉ Maintained/returned to previous status ○ Transitioned to Selected Reserves ○ Transitioned to IRR ○ Transitioned to ING ○ Retired from Military Service ○ Separated from Military Service

Current Contact Information:
Phone: 7084306991
Cell: 8156306793
DSN:
Email: luzmaria.arroyo@us.army.mil
Address: 9148 S 88th Court
Hickory Hills, IL 60457

Total Deployments in Past 5 Years:

OIF	OEF	Other
○ 1	○ 1	○ 1
○ 2	○ 2	○ 2
◉ 3	○ 3	○ 3
○ 4	○ 4	○ 4
○ 5 or more	○ 5 or more	○ 5 or more

Current Unit of Assignment: 416th TEC

Current Assignment Location: Darien, IL

Point of Contact who can always reach you:
Name: Juanita Arroyo
Phone: 7084306991
Email:
Mailing Address: 9148 S 88th Court
Hickory Hills, IL 60457

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number: 321-70-9075

1. Overall, how would you rate your health during the PAST MONTH?
◉ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

2. Compared to before your most recent deployment, how would you rate your health in general now?
○ Much better now than before I deployed ○ Somewhat better now than before I deployed ◉ About the same as before I deployed ○ Somewhat worse now than before I deployed ○ Much worse now than before I deployed

3. During the past 4 weeks, how difficult have physical health problems (illness or injury) made it for you to do your work or other regular daily activities?
◉ Not difficult at all ○ Somewhat difficult ○ Very difficult ○ Extremely difficult

4. During the past 4 weeks, how difficult have emotional problems (such as feeling depressed or anxious) made it for you to do your work, take care of things at home, or get along with other people?
◉ Not difficult at all ○ Somewhat difficult ○ Very difficult ○ Extremely difficult

5. Since you returned from deployment, about how many times have you seen a healthcare provider for any reason, such as in sick call, emergency room, primary care, family doctor, or mental health provider?
○ No visits ◉ 1 visit ○ 2-3 visits ○ 4-5 visits ○ 6 or more

6. Since you returned from deployment, have you been hospitalized? ○ Yes ◉ No

7. During your deployment, were you wounded, injured, assaulted or otherwise physically hurt? ◉ Yes ○ No
If NO, skip to Question 8.

7a. If YES, are you still having problems related to this wound, assault, or injury? ○ Yes ○ No ◉ Unsure

8. In addition to wounds or injuries you listed in question 7, do you currently have a health concern or condition that you feel is related to your deployment? ◉ Yes ○ No ○
If NO, skip to Question 9.

8a. If YES, please mark the item(s) that best describes your deployment-related condition or concern:

○ Fever	○ Dimming of vision, like the lights were going out
○ Cough lasting more than 3 weeks	○ Coughing or straining

PLAINTIFF'S EXHIBIT N Blumberg No. 5113

PLAINTIFF'S EXHIBIT 72 Blumberg No. 5113

○ Trouble breathing	○ Dizzy, light headed, passed out
○ Bad headaches	○ Diarrhea, vomiting, or frequent indigestion/heartburn
○ Generally feeling weak	○ Problems sleeping or still feeling tired after sleeping
○ Muscle aches	○ Trouble concentrating, easily distracted
○ Swollen, stiff or painful joints	○ Forgetful or trouble remembering things
○ Back pain	○ Hard to make up your mind or make decisions
○ Numbness or tingling in hands or feet	○ Increased irritability
○ Trouble hearing	○ Taking more risks such as driving faster
● Ringing in the ears	○ Skin diseases or rashes
● Watery, red eyes	○ Other *(please list)*:

9.a. During this deployment, did you experience any of the following event(s)? *(Mark all that apply)*

(1) Blast or explosion *(IED, RPG, land mine, grenade, etc.)*	● Yes ○ No
(2) Vehicular accident/crash *(any vehicle, including aircraft)*	● Yes ○ No
(3) Fragment wound or bullet wound above your shoulders	○ Yes ● No
(4) Fall	○ Yes ● No
(5) Other event *(for example, a sports injury to your head)*. Describe: Injury to head, boxing	● Yes ○ No

9.b. Did any of the following happen to you, or were you told happened to you, IMMEDIATELY after any of the event(s) you just noted in question 9.a.? *(Mark all that apply)*

(1) Lost consciousness or got "knocked out"	○ Yes ● No
(2) Felt dazed, confused, or "saw stars"	● Yes ○ No
(3) Didn't remember the event	○ Yes ● No
(4) Had a concussion	○ Yes ● No
(5) Had a head injury	○ Yes ● No

9.c Did any of the following problems begin or get worse after the event(s) you noted in question 9.a.? *(Mark all that apply)*

(1) Memory problems or lapses	○ Yes ● No
(2) Balance problems or dizziness	○ Yes ● No
(3) Ringing in the ears	● Yes ○ No
(4) Sensitivity to bright light	● Yes ○ No
(5) Irritability	● Yes ○ No
(6) Headaches	○ Yes ● No
(7) Sleep problems	● Yes ○ No

9.d. In the past week, have you had any of the symptoms you indicated in 9.c.? *(Mark all that apply)*

(1) Memory problems or lapses	○ Yes ● No
(2) Balance problems or dizziness	○ Yes ● No
(3) Ringing in the ears	● Yes ○ No
(4) Sensitivity to bright light	● Yes ○ No
(5) Irritability	○ Yes ● No
(6) Headaches	○ Yes ● No
(7) Sleep problems	○ Yes ● No

DD FORM 2900, JAN 2008

Page 2 of 5 Pages

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number: 321-76-9075

10. Do you have any persistent major concerns regarding the health effects of something you believe you may have been exposed to or encountered while deployed? ○ Yes ● No
If NO, skip to question 11.

10.a If YES, please mark the item(s) that best describe your concern:

○ Animal bites	○ Loud noises
○ Animal bodies *(dead)*	○ Paints
○ Chlorine gas	○ Pesticides
○ Depleted uranium *(If yes, explain)*	○ Radar/Microwaves
○ Excessive vibration	○ Sandblast
○ Fog oils (smoke screen	○ Smoke from burning trash or feces
○ Garbage	○ Smoke from oil fire
○ Human blood, body fluids, body parts of dead bodies	○ Solvents
○ Industrial pollution	○ Tent heater smoke
○ Insect bites	○ Vehicle or truck exhaust fumes
○ Ionizing radiation	○ Other exposures to toxic chemicals or materials, such as ammonia, nitric acid, etc.. *(If yes, explain)*
○ JP8 or other fuels	
○ Lasers	

11. Since return from your deployment, have you had serious conflicts with your spouse, family members, close friends, or at work that continue to cause you worry or concern? ○ Yes ● No ○ Unsure

12. Have you ever had any experience that was so frightening, horrible, or upsetting that, IN THE PAST MONTH, you ....

a. Have had nightmares about it or thought about it when you did not want to?	○ Yes ● No
b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?	○ Yes ● No
c. Were constantly on guard, watchful, or easily startled?	● Yes ○ No
d. Felt numb or detached from others, activities, or your surroundings?	● Yes ○ No

13.a In the PAST MONTH, Did you use alcohol more than you meant to? ○ Yes ● No

b. In the PAST MONTH, have you felt that you wanted or needed to cut down on your drinking? ○ Yes ● No

c How often do you have a drink containing alcohol?
○ Never ○ Monthly or less ○ 2 to 4 times a month ○ 2 to 3 times a week ● 4 or more times a week

d How many drinks containing alcohol do you have on a typical day when you are drinking?
○ 1 or 2 ● 3 or 4 ○ 5 or 6 ○ 7 to 9 ○ 10 or more

e. How often do you have six or more drinks on one occasion?
○ Never ○ Less than monthly ○ Monthly ● Weekly ○ Daily

14. Over the PAST MONTH, have you been bothered by the following problems?

	Not at all	Few or several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	●	○	○	○
b. Feeling down, depressed or hopeless	●	○	○	○

15. Would you like to schedule a visit with a healthcare provider to further discuss your health concern(s)? ● Yes ○ No

16. Are you currently interested in receiving information or assistance for a stress, emotional or alcohol concern? ○ Yes ● No

17. Are you currently interested in receiving assistance for a family or relationship concern? ○ Yes ● No

15. Would you like to schedule a visit with a chaplain or a community support counselor? ○ Yes ● No

DD FORM 2900, JAN 2008 Page 3 of 5 Pages

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number: 321-70-9075 Date *(dd/mmm/yyyy)*: 05-Oct-2010

Health Care Provider Only

Provider Review and Interview

1. Review symptoms and deployment concerns identified on form:

● Confirmed screening results as reported

○ Screening results modified, amended, clarified during interview:

2. Ask behavioral risk questions. Conduct risk assessment.

a. Over the PAST MONTH, have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way? ○ Yes ● No

IF YES, about how often have you been bothered by these thoughts? ○ Very few days ○ More than half of the time ○ Nearly every day

b. Since return from your deployment, have you had thoughts or concerns that you might hurt or lose control with someone? ○ Yes ● No ○ Unsure

3. If member reports positive or unsure response to 2.a. or 2.b., conduct risk assessment.

a. Does member pose a current risk for harm to self or others? ○ No, not a current risk ○ Yes, poses a current risk ○ Unsure

b. Outcome of assessment ○ Immediate referral ○ Routine follow-up referral ○ Referral not indicated

4. Alcohol screening result

○ No evidence of alcohol-related problems

● Potential alcohol problem (positive response to either question 13a or 13b and/or AUDIT-C (questions 13c-e) score of 4 or more for men or 3 or more for women)

Refer to PCM for evaluation ● Yes ○ No

5. Traumatic Brain Injury (TBI) risk assessment

○ No evidence of risk based on responses to questions 9.a. - d.

● Potential TBI with persistent symptoms, based on responses to question 9.d.

Refer for additional evaluation. ● Yes ○ No

6. Record additional questions or concerns identified by patient during interview:

DD FORM 2900, JAN 2008 Page 4 of 5 Pages

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number: 321-70-9075 Date *(dd/mmm/yyyy)*: 05-Oct-2010

Assessment and Referral: After my interview with the service member and review of this form, there is a need for further evaluation and follow-up as indicated below. (More than one may be noted for patients with multiple concerns.)

7. Identified Concerns	Minor Concern	Major Concern	Already Under Care: Yes	Already Under Care: No	8. Referral Information	Within 24 hours	Within 7 days	Within 30 days
					a. Primary Care, Family Practice	○	○	●
● Physical Symptom(s)	●	○	○	●	b. Behavioral Health in Primary Care	○	○	●
○ Exposure Symptom(s)	○	○	○	○	c. Mental Health Specialty Care	○	○	○
○ Depression symptoms	○	○	○	○	d. Other specialty care:			
● PTSD symptoms	●	○	○	●	Audiology	○	○	○
○ Anger/Aggression	○	○	○	○	Cardiology	○	○	○
○ Suicidal Ideation	○	○	○	○	Dentistry	○	○	○
○ Social/Family Conflict	○	○	○	○	Dermatology	○	○	○
● Alcohol Use	○	●	○	●	ENT	○	○	○
○ Other ______	○	○	○	○	GI	○	○	○
9. Comments:					Internal Medicine	○	○	○
Referral document for symptoms of TBI, PTSD, excessive					Neurology	○	○	○
use of alcohol, and red, painful eyes, the left					OB/GYN	○	○	○
worse than the right Militaryvideosource.com					Ophthalmology	○	○	○

0000913

49 reviewed with pt				
	Optometry	○	○	○
	Orthopedics	○	○	○
	Pulmonology	○	○	○
	Urology	○	○	○
	e. Care Manager, Care Manager	○	○	○
	f. Substance Abuse Program	○	○	○
	g. Health Promotion, Health Education	○	○	○
	h. Chaplain	○	○	○
	i. Family Support, Community Service	○	○	○
	j. Military OneSource	○	○	○
	k. Other	○	○	○
	l. No referral made ○			

I certify that this review process has been completed.
10. Provider's signature and stamp:

Lora Mayhenke
05-Oct-2010

ICD-9 Code for this visit: V70.5 _ F

Ancillary Staff/Administrative Section

11. Member was provided the following:	12. Referral was made to the following healthcare or support system:
◉ Health Education and Information	○ Military Treatment Facility
◉ Health Care Benefits and Resources Information	○ Division/Unit-based medical resource
○ Appointment Assistance	◉ VA Medical Center or Community Clinic
○ Service member declined to complete form	◉ Vet Center
○ Service member declined to complete Initial wellness assessment	○ TRICARE Provider
◉ LDD	○ Contact Support:
○ Other:	○ Community Service:
	○ Other:
	○ None

This form must be completed electronically. Handwritten forms will not be accepted.

POST-DEPLOYMENT HEALTH ASSESSMENT (PDHA)

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, 1074f, 3013, 5013, 8013 and E.O. 9397.

PRINCIPAL PURPOSE(S): To assess your state of health after deployment in support of military operations and to assist military healthcare providers in identifying and providing present and future medical care you may need. The information you provide may result in a referral for additional healthcare that may include medical, dental or behavioral healthcare or diverse community support services.

ROUTINE USE(S): In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, to other Federal and State agencies and civilian healthcare providers as necessary, in order to provide necessary medical care and treatment. Responses may be used to guide possible referrals.

DISCLOSURE: Voluntary. If not provided, healthcare WILL BE furnished, but comprehensive care may not be possible.

INSTRUCTIONS: Please read each question completely and carefully before entering your response or marking your selection.YOU ARE ENCOURAGED TO ANSWER EACH QUESTION. ANSWERING THESE QUESTIONS WILL NOT DELAY YOUR RETURN HOME. Withholding or providing inaccurate information may impair a healthcare provider's ability to identify health problems and refer you to appropriate sources for additional evaluation or treatment. If you do not understand a question, please ask for help.

DEMOGRAPHICS

Last Name: ARROYO
First Name: LUZMARIA
Middle Initial:
Social Security Number: 321-70-9075
Today's Date (dd/mmm/yyyy): 14-Apr-2010
Name of Your Unit during this Deployment: 308th CA BDE, DET 29
Date of Birth (dd/mmm/yyyy): 01-Jan-1981
Gender: ○ Male ◉ Female

Service Branch:
- ○ Air Force
- ◉ Army
- ○ Coast Guard
- ○ Marine Corps
- ○ Navy
- ○ GS Employee
- ○ Other

Component:
- ○ Active Duty
- ○ National Guard
- ◉ Reserves
- ○ Civilian Government Employee
- ○ Other

Pay Grade:
- ○ E1 ○ E2 ○ E3 ○ E4 ○ E5 ◉ E6 ○ E7 ○ E8 ○ E9
- ○ O1 ○ O2 ○ O3 ○ O4 ○ O5 ○ O6 ○ O7 ○ O8 ○ O9 ○ O10
- ○ W1 ○ W2 ○ W3 ○ W4 ○ W5
- ○ Other

Date of arrival in theater (dd/mmm/yyyy): 26-May-2009
Date of departure from theater (dd/mmm/yyyy): 10-Apr-2010
Name of Operation:

Location of Operation. To what areas were you mainly deployed (land-based operations for more than 30 days)? (Please mark all that apply, including the number of months spent at each location.)

Country 1:	IRAQ	Time at location (months):	12
Country 2:		Time at location (months):	
Country 3:		Time at location (months):	
Country 4:		Time at location (months):	
Country 5:		Time at location (months):	

Occupational specialty during this deployment (MOS/AOC, NEC/NOBC, or AFSC): 42A30
Combat specialty: 35B30

Current Contact Information:
Phone: 7084306991
Cell: 01185306816
DSN:
Email: luzmaria.arroyo@us.army.mil
Address: 9148 So. 88th Ct
Hickory Hills, IL 60457

Point of Contact who can always reach you:
Name: Juanita Arroyo
Phone: 7084306991
Email:
Mailing Address: 9148 So. 88th Ct
Hickory Hills, IL 60457

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number: 321-70-9075

1. Overall, how would you rate your health during the PAST MONTH?
   - ○ Excellent
   - ○ Very Good
   - ◉ Good
   - ○ Fair
   - ○ Poor

2. Compared to before this deployment, how would you rate your health in general now?
   - ○ Much better now than before I deployed
   - ○ Somewhat better now than before I deployed
   - ◉ About the same as before I deployed
   - ○ Somewhat worse now than before I deployed
   - ○ Much worse now than before I deployed

3. During the past 4 weeks, how difficult have physical health problems (illness or injury) made it for you to do your work or other regular daily activities?
   - ◉ Not difficult at all
   - ○ Somewhat difficult
   - ○ Very difficult
   - ○ Extremely difficult

4. During the past 4 weeks, how difficult have emotional problems (such as feeling depressed or anxious) made it for you to do your work, take care of things at home, or get along with other people?
   - ○ Not difficult at all
   - ◉ Somewhat difficult
   - ○ Very difficult
   - ○ Extremely difficult

5. How many times were you seen by a healthcare provider (physician, PA, medic, corpsman, etc.) for a medical problem or concern during this deployment?
   10

6. Did you have to spend one or more nights in a hospital as a patient during this deployment?
   - ◉ No
   - ○ Yes. Reason/dates:

7. Were you wounded, injured, assaulted or otherwise hurt during this deployment?
   - ◉ No ○ Yes

7a. IF YES, are you still having problems related to this event?
   - ○ No ○ Yes ○ Unsure

8. For any of the following symptoms, please indicate whether you want to see a healthcare provider sometime. PA medic

corpsman, etc.), were placed on quarters (Dirs) or given light/limited duty (Profile), and whether you are still bothered by the symptom now.

Symptom	Sick Call?		One/Profile?		Still Bothered?		Symptom	Sick Call?		One/Profile?		Still Bothered?	
	No	Yes	No	Yes	No	Yes		No	Yes	No	Yes	No	Yes
Fever	58	O	59	O	60	O	Dizzy, light headed, passed out	O	61	62	O	63	O
Cough lasting more than 3 weeks	64	O	65	O	66	O	Diarrhea	67	O	68	O	69	O
Trouble breathing	O	70	71	O	72	O	Vomiting	73	O	74	O	75	O
Bad headaches	O	76	77	O	78	O	Frequent indigestion/ heartburn	79	O	80	O	81	O
Generally feeling weak	O	82	83	O	84	O	Problems sleeping or still feeling tired after sleeping	O	85	86	O	87	O
Muscle aches	88	O	89	O	90	O	Trouble concentrating, easily distracted	O	91	92	O	93	O
Swollen, stiff or painful joints	94	O	95	O	96	O	Forgetful or trouble remembering things	O	97	98	O	99	O
Back pain	100	O	101	O	102	O	Hard to make up your mind or make decisions	O	103	104	O	105	O
Numbness or tingling in hands or feet	106	O	107	O	108	O	Increased irritability	O	109	110	O	111	O
Trouble hearing	O	112	113	O	114	O	Skin diseases or rashes	115	O	116	O	117	O
Ringing in the ears	O	118	119	O	120	O	Other (please list): stress	O	121	122	O	123	O
Watery, red eyes	O	124	125	O	126	O							
Dimming of vision, like the lights were going out	127	O	128	O	129	O							
Chest pain or pressure	O	130	131	O	132	O							

DD FORM 2796, JAN 2008

Page 2 of 7 Pages

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number: 321-70-9075

9.a. During this deployment, did you experience any of the following events? *(Mark all that apply)*

(1) Blast or explosion (IED, RPG, land mine, grenade, etc.) — (133) No O Yes

(2) Vehicle accident/crash *(any vehicle involved)* — O No (134) Yes

(3) Fragment wound or bullet wound above your shoulders — (135) No O Yes

(4) Fall — (136) No O Yes

(5) Other event *(for example, a sports injury to your head)*. Describe — O No (137) Yes

boxing and competitive

9.b. Did any of the following happen to you, or were you told happened to you, IMMEDIATELY after any of the event(s) you just noted in question 9.a.? *(Mark all that apply)*

(1) Lost consciousness or got "knocked out" — O No (138) Yes

(2) Felt dazed, confused, or "saw stars" — O No (139) Yes

(3) Didn't remember the event — (140) No O Yes

(4) Had a concussion — (141) No O Yes

(5) Had a head injury — (142) No O Yes

9.c. Did any of the following problems begin or get worse after the event(s) you noted in question 9.a.? *(Mark all that apply)*

(1) Memory problems or lapses — (143) No O Yes

(2) Balance problems or dizziness — (144) No O Yes

(3) Ringing in the ears — O No (145) Yes

(4) Sensitivity to bright light — (146) No O Yes

(5) Irritability — (147) No O Yes

(6) Headaches — (148) No O Yes

(7) Sleep problems — (149) No O Yes

9.d. In the past week, have you had any of the symptoms you indicated in 9.c.? *(Mark all that apply)*

(1) Memory problems or lapses — (150) No O Yes

(2) Balance problems or dizziness — (151) No O Yes

(3) Ringing in the ears — O No (152) Yes

(4) Sensitivity to bright light — (153) No O Yes

(5) Irritability — (154) No O Yes

(6) Headaches — (155) No O Yes

(7) Sleep problems — (156) No O Yes

10. Did you encounter dead bodies or see people killed or wounded during this deployment? *(Mark all that apply)*

(157) No O Yes (O Enemy O Coalition O Civilian)

11. Were you engaged in direct combat where you discharged a weapon?

(158) No O Yes (O land O sea O air)

12. During this deployment, did you ever feel that you were in great danger of being killed?

O No (159) Yes

13. Have you ever had any experience that was so frightening, horrible, or upsetting that, IN THE PAST MONTH, you ...

a. Have had nightmares about it or thought about it when you did not want to? — (160) No O Yes

b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it? — (161) No O Yes

c. Were constantly on guard, watchful, or easily startled? — O No (162) Yes

d. Felt numb or detached from others, activities, or your surroundings? — (163) No O Yes

14. Over the PAST MONTH, have you been bothered by the following problems?

	Not at all	Few or several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	O	(164)	O	O
b. Feeling down, depressed, or hopeless	O	(165)	O	O

15. Alcohol is occasionally available during deployments, e.g., R&R, port call, etc. Prior to deploying or during this deployment:

a. Did you use alcohol more than you meant to? — O No (166) Yes

b. Have you felt that you wanted to or needed to cut down on your drinking? — O No (167) Yes

c. How often do you have a drink containing alcohol?

O Never O Monthly or less O 2 to 4 times a month (168) 2 to 3 times a week O 4 or more times a week

d. How many drinks containing alcohol do you have on a typical day when you are drinking?

○ 1 or 2 ○ 3 or 4 ○ 5 or 6 ◉ 7 to 9 ○ 10 or more

e. How often do you have six or more drinks on one occasion?

○ Never ○ Less than monthly ○ Monthly ◉ Weekly ○ Daily

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number: 321-70-9075

16. Are you worried about your health because you were exposed to: *(Mark all that apply)*	No	Yes
Animal bites	◉	○
Animal bodies *(dead)*	◉	○
Chlorine gas	◉	○
Depleted uranium *(If yes, explain)*	◉	○
Excessive vibration	◉	○
Fog oil *(smoke screen*	◉	○
Garbage	○	◉
Human blood, body fluids, body parts, or dead bodies	◉	○
Industrial pollution	○	◉
Insect bites	◉	○
Ionizing radiation	◉	○
JP8 or other fuels	◉	○
Lasers	◉	○
Loud noises	○	◉
Paints	◉	○
Pesticides	◉	○
Radar/Microwaves	◉	○
Sandblast	○	◉
Smoke from burning wood or leaves	○	◉
Smoke from oil fire	○	◉
Solvents	◉	○
Tent heater smoke	◉	○
Vehicle or truck exhaust fumes	○	◉
Other exposures to toxic chemicals or materials, such as ammonia, nitric acid, etc. *(If yes, explain)*	◉	○

17. Were you exposed to any chemicals or other hazard *(chemical, environmental, etc.)* that required you to seek immediate medical care?

◉ No ○ Yes

18. Did you enter or closely inspect any destroyed military vehicles?

◉ No ○ Yes

19. Do you think you were exposed to any chemical, biological, or radiological warfare agents during this deployment?

◉ No ○ Don't know ○ Yes, explain with date and location. _____

20. This question assesses your personal risk for exposure to tuberculosis or other local infectious diseases. Would you say your INDOOR contact with local or 3rd country nationals was:

○ None ○ Minimal *(less than 1 hour per week)* ○ Moderate *(1 or more hours per week, but not daily)* ◉ Extensive *(at least 1 hour per day, every day)*

21. Force Health Protection Measures. Please indicate which of the following items you used during this deployment and how often you used them.

	Daily	Most days	Some days	Rarely	Not available	Not required
DEET insect repellent applied to skin	○	○	○	○	◉	○
Pesticide-treated uniforms	○	○	○	○	◉	○
Eye protection *(non-commercial sunglasses or prescription glasses)*	○	○	◉	○	○	○
Hearing protection	○	○	◉	○	○	○
N 95 or other respirator *(not gas mask)*	○	○	○	○	◉	○
Pills to stay awake, like dexedrine	○	○	○	○	◉	○
Anti-NBC meds	○	○	○	○	◉	○
Pyridostigmine *(nerve agent pill)*	○	○	○	○	◉	○
Nerve agent antidote injector	○	○	○	◉	○	○
Seizure/convulsion antidote injector	○	○	○	◉	○	○
NBC gas mask	○	○	○	◉	○	○
MOPP over garments	○	○	○	◉	○	○

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number: 321-70-9075

22. Did you receive any vaccinations just before or during this deployment?

○ Smallpox *(leaves a scar on the arm)*
◉ Anthrax
○ Botulism
◉ Typhoid
○ Meningococcal
○ Yellow Fever
◉ Other, list: Hiflet,Influenza
○ No
○ Don't know

23. Were you told to take medicines to prevent malaria?

◉ No ○ Yes

If YES, please indicate which medicines you took and whether you missed any doses. *(Mark all that apply)*

Anti-malarial medications	Took All Pills
Chloroquine (Aralen ◉)	○ No ○ Yes
Doxycycline (Vibramycin ◉)	○ No ○ Yes
Mefloquine (Lariam ◉)	○ No ○ Yes
Primaquine	○ No ○ Yes
Other	○ No ○ Yes

24. Would you like to schedule a visit with a healthcare provider to further discuss your health concern(s)? ○ No ◉ Yes

25. Are you currently interested in receiving information or assistance for a stress, emotional or alcohol concern? ○ No ◉ Yes

16. Are you currently interested in receiving assistance for a family or relationship concern? (●) No ( ) Yes

17. Would you like to schedule a visit with a chaplain or a community support counselor? (●) No ( ) Yes

DD FORM 2796, JAN 2008

Page 5 of 7 Pages

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number: 321-70-9075

Health Care Provider Only
Post-Deployment Health Care Provider Review, Interview, and Assessment

1. Do you have any medical or dental problems that developed during this deployment? (●) Yes ( ) No
   If yes, are the problems still bothering you now? (●) Yes ( ) No

2. Are you currently on a profile (or LIMDU) that restricts your activities (light or limited duty)? ( ) Yes (●) No
   If yes: For what reason? _____ ( ) NA
   Is your condition due to an injury or illness that occurred during the deployment? ( ) Yes ( ) No ( ) NA
   Did you have similar problems prior to deployment? ( ) Yes ( ) No ( ) NA
   If so, did your condition worsen during the deployment? ( ) Yes ( ) No ( ) NA

3. Ask the following behavioral risk questions. Conduct risk assessment as necessary.
   a. Over the PAST MONTH, have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way? ( ) Yes (●) No
      IF YES, about how often have you been bothered by these thoughts? ( ) A few days ( ) More than half of the time ( ) Nearly every day
   b. Over the PAST MONTH, have you had thoughts or concerns that you might hurt or lose control with someone? ( ) Yes (●) No ( ) Unsure

4. If member reports YES or UNSURE responses to 3.a. or 3.b., conduct risk assessment.
   a. Does member pose a current risk for harm to self or others? ( ) No, not a current risk ( ) Yes, poses a current risk ( ) Unsure
   b. Outcome of assessment ( ) Immediate referral ( ) Routine follow-up referral ( ) Referral not indicated

5. Alcohol screening result
   ( ) No evidence of alcohol-related problems
   (●) Potential alcohol problem (positive response to either question 15a or 15b and/or AUDIT-C (questions 16c-e) score of 4 or more for men or 3 or more for women)
   Refer to PCM for evaluation. (●) Yes ( ) No

6. During this deployment have you sought, or do you now intend to seek, counseling or care for your mental health? (●) Yes ( ) No

7. Traumatic Brain Injury (TBI) risk assessment
   (●) No evidence of risk based on responses to questions 9 a. - d
   ( ) Potential TBI with persistent symptoms, based on responses to question 9.d.
   Refer for additional evaluation. ( ) Yes ( ) No

8. Tuberculosis risk assessment, based on response to question 20.
   ( ) Minimal risk
   (●) Increased risk
   Recommend tuberculosis skin testing in 80-90 days (●) Yes ( ) No

9. Depleted Uranium (DU) risk assessment, based on responses to question 18 (DU, Yes) or question 18 (Yes).
   (●) No evidence of exposure to depleted uranium
   ( ) Potential exposure to depleted uranium
   Refer to PCM for completion of DD Form 2872 and possible 24-hour urinalysis. ( ) Yes ( ) No

10. Do you have any other concerns about possible exposures or events during this deployment ( ) Yes (●) No

that you feel may affect your health? ○ Yes ● No

Please list your concerns.

11. Do you currently have any questions or concerns about your health? ○ Yes ● No

Please list your concerns.

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number: 321-70-9076

Health Assessment

After my interview/examination of the service member and review of this form, there is a need for further evaluation and follow-up as indicated below. (More than one may be noted for patients with multiple problems. Further documentation of the problem evaluation to be placed in service member's medical record.)

11. Identified Concerns	Minor Concern	Major Concern	Already Under Care: Yes	Already Under Care: No
Physical Symptom(s)	●	○	●	○
Exposure Symptom(s)	○	○	○	○
Environmental	○	○	○	○
Occupational	○	○	○	○
Combat or mission-related	○	○	○	○
Depression symptoms	○	○	○	○
PTSD symptoms	○	○	○	○
Anger/Aggression	○	○	○	○
Suicidal ideation	○	○	○	○
Social/Family Conflict	○	○	○	○
Alcohol Use	○	○	○	○
Other				

12. Referral Information	Within 24 hours	Within 7 days	Within 30 days
a. Primary Care, Family Practice			
b. Behavioral Health in Primary Care			
c. Mental Health Specialty Care			
d. Other specialty care:			
Audiology			
Cardiology			
Dentistry			
Dermatology			
ENT			
GI			
Internal Medicine			
Neurology			
OB/GYN			
Ophthalmology			
Optometry			
Orthopedics			
Pulmonology			
Urology			
e. Case Manager, Care Manager			
f. Substance Abuse Program			
g. Health Promotion, Health Education			
h. Chaplain			
i. Family Support, Community Service			
j. Military OneSource			
k. Other			
l. No referral made ○			

This form must be completed electronically. Handwritten forms will not be accepted.

POST-DEPLOYMENT HEALTH ASSESSMENT (PDHA)

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, 1074f, 3013, 5013, 8013 and E.O. 9397.

PRINCIPAL PURPOSE(S): To assess your state of health after deployment in support of military operations and to assist military healthcare providers in identifying and providing present and future medical care you may need. The information you provide may result in a referral for additional healthcare that may include medical, dental or behavioral healthcare or diverse community support services.

ROUTINE USE(S): In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, to other Federal and State agencies and civilian healthcare providers as necessary, in order to provide necessary medical care and treatment. Responses may be used to guide possible referrals.

DISCLOSURE: Voluntary. If not provided, healthcare WILL BE furnished, but comprehensive care may not be possible.

INSTRUCTIONS: Please read each question completely and carefully before entering your response or marking your selection.YOU ARE ENCOURAGED TO ANSWER EACH QUESTION. ANSWERING THESE QUESTIONS WILL NOT DELAY YOUR RETURN HOME. Withholding or providing inaccurate information may impair a healthcare provider's ability to identify health problems and refer you to appropriate sources for additional evaluation or treatment. If you do not understand a question, please ask for help.

DEMOGRAPHICS

Last Name: ARROYO
First Name: LUZMARIA
Middle Initial:

Social Security Number: 321-70-9075
Today's Date (dd/mmm/yyyy): 13-Apr-2010

Name of Your Unit during this Deployment: 306th CA BDE, DET 29
Date of Birth (dd/mmm/yyyy): 01-Jan-1981
Gender: ○ Male ◉ Female

Service Branch: ○ Air Force ◉ Army ○ Coast Guard ○ Marine Corps ○ Navy ○ OB Employee ○ Other
Component: ○ Active Duty ○ National Guard ◉ Reserves ○ Civilian Government Employee ○ Other
Pay Grade: ○ E1 ○ E2 ○ E3 ○ E4 ○ E5 ◉ E6 ○ E7 ○ E8 ○ E9 ○ O1 ○ O2 ○ O3 ○ O4 ○ O5 ○ O6 ○ O7 ○ O8 ○ O9 ○ O10 ○ W1 ○ W2 ○ W3 ○ W4 ○ W5 ○ Other

Date of arrival in theater (dd/mmm/yyyy): 26-May-2009
Date of departure from theater (dd/mmm/yyyy): 10-Apr-2010
Name of Operation:

Location of Operation. To what areas were you mainly deployed (land-based operations for more than 30 days)? (Please mark all that apply, including the number of months spent at each location.)

Country 1:	IRAQ	Time at location (months):	12
Country 2:		Time at location (months):	
Country 3:		Time at location (months):	
Country 4:		Time at location (months):	
Country 5:		Time at location (months):	

Occupational specialty during this deployment (MOS/AOC, NEC/NOBC or AFSC): 42A3O

Combat specialty: 38B3O

Current Contact Information:
Phone: 7084306991
Cell: 8155305810
DSN:
Email: luzmaria.arroyo@us.army.mil
Address: 9148 So. 88th CT
Hickory Hills, IL 60457

Point of Contact who can always reach you:
Name: Juanita Arroyo
Phone: 7084306991
Email:
Mailing Address: 9148 So. 88th CT
Hickory Hills, IL 60457

DD FORM 2796, JAN 2008 PREVIOUS EDITION IS OBSOLETE. Page 1 of 7 Pages

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number: 321-70-9075

1. Overall, how would you rate your health during the PAST MONTH?
○ Excellent ○ Very Good ◉ Good ○ Fair ○ Poor

2. Compared to before this deployment, how would you rate your health in general now?
○ Much better now than before I deployed ○ Somewhat better now than before I deployed ◉ About the same as before I deployed ○ Somewhat worse now than before I deployed ○ Much worse now than before I deployed

3. During the past 4 weeks, how difficult have physical health problems (like walking) made it for you to do your work or other regular daily activities?
◉ Not difficult at all ○ Somewhat difficult ○ Very difficult ○ Extremely difficult

4. During the past 4 weeks, how difficult have emotional problems (such as feeling depressed or anxious) made it for you to do your work, take care of things at home, or get along with other people?
○ Not difficult at all ◉ Somewhat difficult ○ Very difficult ○ Extremely difficult

5. How many times were you seen by a healthcare provider (physician, PA, medic, corpsman, etc.) for a medical problem or concern during this deployment?
10

6. Did you have to spend one or more nights in a hospital as a patient during this deployment?
◉ No ○ Yes. Reason/dates:

7. Were you wounded, injured, assaulted or otherwise hurt during this deployment?
◉ No ○ Yes

7a. IF YES, are you still having problems related to this event?
○ No ○ Yes ○ Unsure

8. For any of the following symptoms, please indicate whether you want to see a healthcare provider (physician, PA, medic

corpsman, etc.), were placed on quarters (Quar) or given light/limited duty (Profile), and whether you are still bothered by the symptom now.

Symptom	Sick Call?		Quar/Profile?		Still Bothered?		Symptom	Sick Call?		Quar/Profile?		Still Bothered?	
	No	Yes	No	Yes	No	Yes		No	Yes	No	Yes	No	Yes
Fever	○	○	○	○	○	○	Dizzy, light headed, passed out	○	○	○	○	○	○
Cough lasting more than 3 weeks	○	○	○	○	○	○	Diarrhea	○	○	○	○	○	○
Trouble breathing	○	○	○	○	○	○	Vomiting	○	○	○	○	○	○
Bad headaches	○	○	○	○	○	○	Frequent indigestion/ heartburn	○	○	○	○	○	○
Generally feeling weak	○	○	○	○	○	○	Problems sleeping or still feeling tired after sleeping	○	○	○	○	○	○
Muscle aches	○	○	○	○	○	○	Trouble concentrating, easily distracted	○	○	○	○	○	○
Swollen, stiff or painful joints	○	○	○	○	○	○	Forgetful or trouble remembering things	○	○	○	○	○	○
Back pain	○	○	○	○	○	○	Hard to make up your mind or make decisions	○	○	○	○	○	○
Numbness or tingling in hands or feet	○	○	○	○	○	○	Increased irritability	○	○	○	○	○	○
Trouble hearing	○	○	○	○	○	○	Skin diseases or rashes	○	○	○	○	○	○
Ringing in the ears	○	○	○	○	○	○	Other (please list): stress	○	○	○	○	○	○
Watery, red eyes	○	○	○	○	○	○							
Dimming of vision, like the lights were going out	○	○	○	○	○	○							
Chest pain or pressure	○	○	○	○	○	○							

DD FORM 2796, JAN 2008

Page 2 of 7 Pages

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number: 321-70-9075

9.a. During this deployment, did you experience any of the following events? *(Mark all that apply)*

(1) Blast or explosion (IED, RPG, land mine, grenade, etc.)	○ No	○ Yes
(2) Vehicular accident/crash (any vehicle, including aircraft)	○ No	○ Yes
(3) Fragment wound or bullet wound above your shoulders	○ No	○ Yes
(4) Fall	○ No	○ Yes
(5) Other event (for example, a sports injury to your head). Describe: hazing and combatives	○ No	○ Yes

9.b. Did any of the following happen to you, or were you told happened to you, IMMEDIATELY after any of the event(s) you just noted in question 9.a.? *(Mark all that apply)*

(1) Lost consciousness or got "knocked out"	○ No	○ Yes
(2) Felt dazed, confused, or "saw stars"	○ No	○ Yes
(3) Didn't remember the event	○ No	○ Yes
(4) Had a concussion	○ No	○ Yes
(5) Had a head injury	○ No	○ Yes

9.c. Did any of the following problems begin or get worse after the event(s) you noted in question 9.a.? *(Mark all that apply)*

(1) Memory problems or lapses	○ No	○ Yes
(2) Balance problems or dizziness	○ No	○ Yes

9.d. In the past week, have you had any of the symptoms you indicated in 9.c.? *(Mark all that apply)*

(1) Memory problems or lapses	○ No	○ Yes
(2) Balance problems or dizziness	○ No	

This form must be completed electronically. Handwritten forms will not be accepted.

POST-DEPLOYMENT HEALTH ASSESSMENT (PDHA)

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, 1071-87, 3013, 8013 and E.O. 9397

PRINCIPAL PURPOSE(S): To assess your state of health after deployment in support of military operations and to assist military healthcare providers in identifying and providing present and future medical care you may need. The information you provide may result in a referral for additional healthcare that may include medical, dental or behavioral healthcare or diverse community support services.

ROUTINE USE(S): In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, to other Federal and State agencies and civilian healthcare providers, as necessary, in order to provide necessary medical care and treatment. Responses may be used to guide possible referrals.

DISCLOSURE: Voluntary. If not provided, healthcare WILL BE furnished, but comprehensive care may not be possible.

INSTRUCTIONS: Please read each question completely and carefully before entering your response or marking your selection. YOU ARE ENCOURAGED TO ANSWER EACH QUESTION. ANSWERING THESE QUESTIONS WILL NOT DELAY YOUR RETURN HOME. Withholding or providing inaccurate information may impair a healthcare provider's ability to identify health problems and refer you to appropriate sources for additional evaluation or treatment. If you do not understand a question, please ask for help.

DEMOGRAPHICS

Last Name	First Name	Middle Initial
ARROYO	LUZMARIA	

Social Security Number: 321-70-9075

Today's Date (dd/mm/yyyy): 16-Mar-2010

Name of Your Unit during this Deployment: 303th CA BDE, DET 29

Date of Birth (dd/mm/yyyy): 01-Jan-1961

Gender: ○ Male ◉ Female

Service Branch: ○ Air Force ◉ Army ○ Coast Guard ○ Marine Corps ○ Navy ○ DS Employee ○ Other

Component: ○ Active Duty ○ National Guard ◉ Reserves ○ Civilian Government Employee ○ Other

Pay Grade: ○ E1 ○ E2 ○ E3 ○ E4 ○ E5 ◉ E6 ○ E7 ○ E8 ○ E9 ○ O1 ○ O2 ○ O3 ○ O4 ○ O5 ○ O6 ○ O7 ○ O8 ○ O9 ○ O10 ○ W1 ○ W2 ○ W3 ○ W4 ○ W5 ○ Other

Date of arrival in theater (dd/mm/yyyy): 26-May-2009

Date of departure from theater (dd/mm/yyyy): 10-Apr-2010

Name of Operation: Iraq: Freedom

Location of Operation. To what areas were you mainly deployed (land-based operations for more than 30 days)? (Please mark all that apply, including the number of months spent at each location.)

Country 1:	IRAQ	Time at location (months):	12
Country 2:		Time at location (months):	
Country 3:		Time at location (months):	
Country 4:		Time at location (months):	
Country 5:		Time at location (months):	

Occupational specialty during this deployment (MOS/AOC, NEC/NOBC, or AFSC): 42A3O

Combat specialty: 38B3O

Current Contact Information:		Point of Contact who can always reach you:	
Phone:		Name:	Juanita Arroyo
Cell:	8156305810	Phone:	708-430-8991
DSN:		Email:	
Email:	luzmaria.arroyo@us.army.mi	Mailing Address:	9148 So. 88th CT
Address:	9148 So. 88th CT		Hickory Hills , IL 60457
	Hickory Hills , IL 60457		

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number: 321-70-9075

1. Overall, how would you rate your health during the PAST MONTH?
◉ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

2. Compared to before this deployment, how would you rate your health in general now?
○ Much better now than before I deployed ◉ Somewhat better now than before I deployed ○ About the same as before I deployed ○ Somewhat worse now than before I deployed ○ Much worse now than before I deployed

3. During the past 4 weeks, how difficult have physical health problems (illness or injury) made it for you to do your work or other regular daily activities?
◉ Not difficult at all ○ Somewhat difficult ○ Very difficult ○ Extremely difficult

4. During the past 4 weeks, how difficult have emotional problems (such as feeling depressed or anxious) made it for you to do your work, take care of things at home, or get along with other people?
○ Not difficult at all ◉ Somewhat difficult ○ Very difficult ○ Extremely difficult

5. How many times were you seen by a healthcare provider (physician, PA, medic, corpsman, etc.) for a medical problem or concern during this deployment?
9

6. Did you have to spend one or more nights in a hospital as a patient during this deployment?
◉ No ○ Yes. Reason/dates

7. Were you wounded, injured, assaulted or otherwise hurt during this deployment?
◉ No ○ Yes

7a. IF YES, are you still having problems related to this event?
○ No ○ Yes ○ Unsure

8. For any of the following symptoms, please indicate whether you want to see a healthcare provider (physician, PA, medic

...ry of the following symptoms, please indicate whether you went to see a medical provider (physician, PA, nurse, corpsman, etc.), were placed on quarters *(Qtrs)* or given light/limited duty *(Profile)*, and whether you are still bothered by the symptom now.

Symptom	Sick Call?		Qtrs/Profile?		Still Bothered?		Symptom	Sick Call?		Qtrs/Profile?		Still Bothered?	
	No	Yes	No	Yes	No	Yes		No	Yes	No	Yes	No	Yes
Fever	1	○	2	○	3	○	Dizzy, light headed, passed out	○	4	5	○	6	○
Cough lasting more than 3 weeks	7	○	8	○	9	○	Diarrhea	10	○	11	○	12	○
Trouble breathing	○	13	14	○	15	○	Vomiting	16	○	17	○	18	○
Bad headaches	○	19	20	○	21	○	Frequent indigestion/ heartburn	22	○	23	○	24	○
Generally feeling weak	○	25	26	○	27	○	Problems sleeping or still feeling tired after sleeping	○	28	29	○	30	○
Muscle aches	31	○	32	○	33	○	Trouble concentrating, easily distracted	○	34	35	○	36	○
Swollen, stiff or painful joints	37	○	38	○	39	○	Forgetful or trouble remembering things	○	40	41	○	42	○
Back pain	43	○	44	○	45	○	Hard to make up your mind or make decisions	○	46	47	○	48	○
Numbness or tingling in hands or feet	49	○	50	○	51	○	Increased irritability	○	52	53	○	54	○
Trouble hearing	○	55	56	○	57	○	Skin diseases or rashes	58	○	59	○	60	○
Ringing in the ears	○	61	62	○	63	○	Other *(please list)* stress	○	64	65	○	66	○
Watery red eyes	○	67	68	○	69	○							
Dimming of vision, like the lights were going out	70	○	71	○	72	○							
Chest pain or pressure	○	73	74	○	75	○							

DD FORM 2796, JAN 2008 — Page 2 of 7 Pages

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number: 321 70-9076

9.a. During this deployment, did you experience any of the following events? *(Mark all that apply)*

(1) Blast or explosion *(IED, RPG, land mine grenade, etc.)*	1 No	○ Yes
(2) Vehicular accident/crash *(any vehicle, including aircraft)*	○ No	2 Yes
(3) Fragment wound or bullet wound above your shoulders	3 No	○ Yes
(4) Fall	4 No	○ Yes
(5) Other event *(for example, a sports injury to your head)* Describe. boxing and combatives	○ No	5 Yes

9.b. Did any of the following happen to you, or were you told happened to you, IMMEDIATELY after any of the event(s) you just noted in question 9.a.? *(Mark all that apply)*

(1) Lost consciousness or got "knocked out"	○ No	6 Yes
(2) Felt dazed, confused, or "saw stars"	○ No	7 Yes
(3) Didn't remember the event	8 No	○ Yes
(4) Had a concussion	9 No	○ Yes
(5) Had a head injury	10 No	○ Yes

9.c. Did any of the following problems begin or get worse after the event(s) you noted in question 9.a.? *(Mark all that apply)*

(1) Memory problems or lapses	11 No	○ Yes
(2) Balance problems or dizziness	12 No	○ Yes
(3) Ringing in the ears	○ No	13 Yes
(4) Sensitivity to bright light	14 No	○ Yes
(5) Irritability	15 No	○ Yes
(6) Headaches	16 No	○ Yes
(7) Sleep problems	17 No	○ Yes

9.d. In the past week, have you had any of the symptoms you indicated in 9.c.? *(Mark all that apply)*

(1) Memory problems or lapses	18 No	○ Yes
(2) Balance problems or dizziness	19 No	○ Yes
(3) Ringing in the ears	○ No	20 Yes
(4) Sensitivity to bright light	21 No	○ Yes
(5) Irritability	22 No	○ Yes
(6) Headaches	23 No	○ Yes
(7) Sleep problems	24 No	○ Yes

10. Did you encounter dead bodies or see people killed or wounded during this deployment? *(Mark all that apply)*
○ Yes (○ Enemy ○ Coalition ○ Civilian)

11. Were you engaged in direct combat where you discharged a weapon?
○ Yes (○ land ○ sea ○ air)

12. During this deployment, did you ever feel that you were in great danger of being killed?
25 Yes

13. Have you ever had any experience that was so frightening, horrible, or upsetting that, IN THE PAST MONTH, you ....

a. Have had nightmares about it or thought about it when you did not want to?	26 No	○ Yes
b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?	27 No	○ Yes
c. Were constantly on guard, watchful, or easily startled?	28 No	○ Yes
d. Felt numb or detached from others, activities, or your surroundings?	29 No	○ Yes

14. Over the PAST MONTH, have you been bothered by the following problems?

	Not at all	Few or several days	More than half the days	Nearly every day
	○	30	○	